VA Healthcare Network
Upstate New York
Stratton VA Medical Center

2004 – 2005
CANCER PROGRAM
Annual Report

TABLE OF CONTENTS

COMPREHENSIVE CANCER COMMITTEE

The Cancer Committee includes representatives of professional specialists as recommended by the American College of Surgeons with areas of responsibilities including: coordinating educational activities for nursing staff, students and professionals; coordinating multi-disciplinary treatment groups such as Oncology,

Radiation Oncology and Hematology related clinics and Tumor Board; overseeing the functioning of the Tumor Registry; and coordinating PCE studies.

The Cancer Committee is responsible for discussing the diagnosis and treatment of patients with malignancy within the facility as well as review medical records of cancer patients.

2005 MEMBERSHIP

E. Ball, CCRP	Representative Clinical Research
B. Bates, MD	Chief of Staff
L. Carpinello-Dillenbeck, R.T.(r)(m)	Representative Women's Health
E. Cunniff, LCSW	Representative Social Work
M. De Mars, RN	Representative Rad/Onc Nurse Coordinator
I. Eglitis, DDS MS	Representative Dental
S. Mehdi, MD	Representative Hem/Onc
G. Hatoum, MD	Representative Radiation Onc & ACoS Liaison
L. Hoffman-Hogg, RN MS AOCN	Cancer Program Director
R. Ilves, MD	Representative Thoracic Surgery
L. Kelly, RN	Representative Mental Health
D. Keyser, RN	CQI Coordinator
D. Kupiak, RPh	Representative Pharmacy
C.Y. Lee, MD	Representative Pathology/ Laboratory
M. Martin, RN	Representative Education
B. McCandless, MD	Representative Diagnostic Imaging-Nuclear Med
B. Moser, RD	Representative Nutrition
N. Memon, MD	Representative Primary Care
N. Nelson, RN	Representative Advanced Illness
S. Osborne, RN	Representative Palliative Care
C. Reilly, MD	Representative Med/Onc
C. Schwartz, MD	Representative Diagnostic Imaging
S. Silver, MD	Representative Otolaryngology
D. Spath, RN	Associate Director Nursing & Patient Services
L. VanWie, CTR	Tumor Registry
M. Velardi, RN	Oncology/Hematology Nurse Coordinator
H. Wilbur, MD	Representative Urology
B. Williams, LPN	Tumor Registry
T. Wu, MD	Representative General Surgery

COMPREHENSIVE CANCER COMMITTEE'S REPORT 2004-2005

December 2005 marks the end of my fourth year as cancer committee chairman. In each of the four years I have had the opportunity to observe the unique role that this committee has taken in its commitment to patient care and in its

administration of vital clinical and educational issues. The members are surely to be congratulated for their efforts and work done on behalf of the hospital and the patient's it serves. Much of the work and ongoing endeavors related to individual members and their departments are recounted in detail in this annual report.

The cancer committee is charged with developing and evaluating annual goals, many of which are not achievable by one person or in a single year. Important goals of previous years have been adopted and continued. The goals are not outlined in the annual report and deserve mentioning here.

The goal of increasing the awareness of the Faircare program by developing a monthly educational class for new house-staff members was met and proved to be quite successful increasing referrals by 10%. The Community Outreach goal for women's health, directed by Linda Carpinello-Dillenbeck, was met and marked an unprecedented increase in the number of Outreach events. Meeting this goal showed that the Stratton Mammography Program has been highly successful. A prostate brachytherapy goal was set to determine whether ACR (American College of Radiology) practice guidelines were being met as well as to compare our hospital's data to national data. Dr. George Hatoum has reported that this goal has been achieved. ACR practice guidelines are being met and the data show excellent results, results that are comparable to the best results available in the United States. An important goal achieved this year was that of obtaining CME credit for the tumor board and for this hospital's current and future educational programs. Accrual of CME credits will begin on October 4, 2005. This one goal, adopted and resurrected from prior years, is a tribute to the perseverance and teamwork of many. It not only has brought CME to this institution but has opened another level of communication with our neighboring university hospital.

Three other goals are ongoing and are worth mentioning. A pain management goal has been addressed by Monica Velardi with the development and distribution of a pain 'Quick Card' system, a brilliant idea for patients to report pain and to improve their quality of life. A two-year goal has been designed to help improve and maintain timeliness of treatment for head and neck cancer patients this will help keep patients within the clinical pathway system previously established by ENT. A goal to develop a Cancer Program Education Brochure is nearing completion. This informative brochure will increase cancer awareness among physicians and patients and will include information regarding each department involved in treating the cancer patient.

The chairman would like to recognize the achievements and contributions made by Dr. Hatoum, the committee's liaison to the American Cancer Society and Dr. Mehdi, oncologist and co-chair of this committee. The contributions of both physicians have been vital to the stability of this cancer program. This past year both Drs. Hatoum and Mehdi reviewed the AJCC staging of our cancer patients to determine if AJCC staging was being practiced according to the AJCC guidelines. This was no small undertaking and their findings were quite favorable. Dr. Hatoum reported the results of the American College of Surgeons and the "prior contingency" placed on the cancer program at the last site visit was removed allowing complete and unrestricted approval of the cancer program by the College.

Dr. Hatoum, as the committee's liaison, participated actively with the American Cancer Society and gained the position of Chairman of the Physician Liaison Committee of Upstate New York. This is a tribute to his hard work. He also has been appointed by the cancer committee to chair the CME physician planning committee. He is responsible for the Larynx treatment update in this annual report. He and Dr. Mehdi recently became co-investigators on the CALGB protocol giving a renewed jump-start to the research program. Dr. Hatoum, working with the ENT service, will be co-investigating two clinical trials designed to study electroporation of Bleomycin in some head and neck cancer patients.

The Commission on Cancer has established an annual update process for all approved cancer programs to facilitate the ongoing recording of cancer program activity. This 'Survey Application Record', commonly known as the SAR or SARs, is accessed on-line. Here update screens are edited, standards are recorded and self assessment ratings are entered. This year the SAR completion date was September 30, 2005 and only a short notification was given. A small subcommittee was formed to help with this process and the Chairman would like to express appreciation to Diane Kaiser for her valuable contributions and once again to the tumor registrars for their hard work.

The year 2006 will mark another survey year for the VA's cancer program. The American College of Surgeons is offering a special "VA Survey Savvy" scheduled for March 23, 2006 at the College Headquarters in Chicago. The workshop will "cover the modifications of the standard, introduction of the VA SAR, and allow VA staff to interact with several members of the surveyor team that have experience evaluating VA facilities." It is expected that a few key members of this committee will participate in this workshop.

The cancer committee is among the most active of all hospital committees and is responsible for administrating and implementing a multitude of complex issues in accordance with the Commission on Cancer. All members of this committee deserve recognition and commendation for their efforts and strong commitment to patient care.

STEVEN SILVER, M.D.
Chairman, Cancer Committee

ONGOING AND NEW INITIATIVES

Cancer Survivor's Celebration: The Thirteenth Annual Cancer Survivors Celebration was held on Friday June 3, 2005. Over 200 cancer survivors, their guests and staff members attended this celebration of life. Mr. Frank Brodzik, Hematology/Oncology Physician Assistant, spoke on survivorship. Donald W. Stuart, Corporate Compliance Officer, spoke from the perspective of a survivor. Rachelle Vishneowski, Music Therapist, led everyone in the National Anthem. The moderator for this event was Lori Hoffman-Hogg - Cancer Program Administrative Director. The keynote address was delivered by our hospital director, Mary Ellen Piche`. The Tri-County Council of Vietnam Era Veterans served as color guard. The VA Nutrition/Food Service catered both breakfast and lunch.

This is truly a homegrown event that has much support and involvement of many hospital personnel. The planning committee is comprised of employees from many disciplines within the institution whose unselfish involvement is a good example of their dedication to our veterans.

This annual event would not be possible without the kindness of our sponsor, Vet Care. Numerous employees and patients donated beautiful hand-crafted items for our raffle. Proceeds from the raffle help to offset the cost of the event. Our hospital volunteers helped with registration and distribution of lunch. The American Cancer Society participated, as they have each year, by providing patient and public education materials including books, pamphlets and other education materials on prevention, detection, treatment and survivorship. This year's celebration was again, an enormous success. We are already looking forward to and beginning to plan our Fourteenth Annual Celebration to be held on June 2nd of 2006.

Outreach: Referral links have been developed with all of our Community Based Outpatient Clinics (CBOCs). CBOCs now have access to CPRS and can look up patient information. In order to assure optimal information flow, computer access to clinical data at these centers has been achieved. When we see a patient from one of our CBOCs we can call up all laboratory, pathology and radiographic data on our system. This has proven to be invaluable in seeing these patients as well as in handling diagnostic and treatment advice at a distance.

My HealtheVet is an Internet-based program that creates a secure and robust online environment where veterans can create and maintain a personal health record. The My HealtheVet website (http://www.myhealth.va.gov) provides easy access to trusted patient health education and resources, one-stop access to VA benefits and health information and several powerful online tools such as:

1) A personal health journal to document over the counter medications and herbals, allergies, military health history, medical events and tests and immunizations;
2) A personal information vault to keep updated contact information, emergency contacts, information about health care providers, health insurance, and both VA and non-VA treatment locations;
3) Personal *e*-logs to record and track personal health readings including blood pressure, blood sugar, cholesterol, heart rate, body temperature, weight and pain;
4) Online calendar to set and track appointments and other events.

Additional features are being added to My HealtheVet in incremental phases. Future releases will extend access to services such as online prescription refills (Aug, 2005), and the ability to view scheduled appointments and co-payment balances.

At the Albany VAMC, a dedicated My HealtheVet/Planetree Health Resource Center is scheduled to open July 15, 2005. It will house 3 private computer/printer stations, health information books, pamphlets, and videos, as well as the Health Touch kiosk which will also provide health information in lay language.

Numerous My HealtheVet publicity events have taken place and will continue to take place to inform Veterans of this new powerful resource.

Psychosocial Support: Psychological support is available for patients and families who request help in coping with the diagnosis of a chronic or terminal condition. A psychiatrist, psychologist, social worker and advanced practice nurse with expertise in working with cancer patient's is available during clinic hours to provide assessment, supportive individual and family counseling and relaxation therapy to patients undergoing chemotherapy and radiation therapy. Appropriate referrals for ongoing psychological support are made when necessary. Behavioral Health is integrated with Primary Care and sees patients referred by the Primary Provider for any behavioral, mental status changes, or other mental health issues. There is a .25 Psychologist assigned to the Pain Management Clinic and each Primary Care Clinic in the hospital, and at least a .5 Psychologist assigned to all of the Primary Care Teams. In addition, consultations are offered for patients on the Medical-Surgical Units.

During scheduled clinic hours, a social worker provides support to patients and families and assists with home care needs, transportation, writing of advance directives and other concrete services. In addition, we have a strong networking relationship and patients have multiple options for community based support groups. We also have our own employees trained to offer the "I Can Cope" program to our cancer patient population.

Tumor Registry: 2004-05 has proven to be a challenging and exciting period for the Tumor Registry. The Registry has continuously adapted to meet the changing demands of the institution as well as State and National guidelines and requirements.

As of March 1998, the VA Central Cancer Registry has been up and operating in Washington, DC. The Stratton VA has contributed 1997 - 2003 data, performed the necessary edits and successfully participated to provide a national cancer data source based on veteran data.

Tumor Registry continues with the process improvement project initiated in 1999 with the Community Based Outpatient Clinic RN's for abnormal lab results that appear to have a delay in follow-up during Tumor Registry case findings. These cases continue to be summarized and forwarded to the CBOC RNs and/or the Primary Care Physician via e-mail to ensure the appropriate follow-up and/or work-up. This has proven very useful in decreasing and/or eliminating lag time of patient care. New abnormals are not only detected earlier, but a formal notification process is now in place for primary providers and reported at the weekly Tumor Board Conference. The Registry staff has also been working closely with the Information Systems (IS) staff in creating a VISTA option for monitoring TNM staging by the managing physician which will help us meet the American College of Surgeon Standard 4.3 documenting compliance and accuracy.

The Registry continues to participate in the NCDB (National Cancer Data Base), adding our data in order to better evaluate local vs. national trends in cancer treatment and survival.

Tumor Registrars, Bernice Williams, LPN and Linda VanWie, CTR both attended a CME credited educational activity titled Coding Cancer that was held at St. Peter's hospital which was presented by New York State Department of Health.

TUMOR REGISTRY REPORT

The Tumor Registry at the VA Medical Center has a reference date of January 1955 and currently utilizes a computerized/manual system. In addition to registering and following patients with a diagnosis of malignancy, the Registry provides data for research and education of staff. Interfacing with all of the components that make up the Cancer Program, the Registry helps promote quality patient care as well as the needs of future cancer patients. The registry is currently staffed by Linda VanWie, CTR and Bernice Williams, LPN.

F/UP RATE FOR PATIENTS DX FROM REGISTRY DATE 1955	NUMBER	% PERCENT
Total Alive Under Follow-up	2,055	100%
Total Unknown Status	284	4%
Total Successful Follow-up Rate (all pts) (** should be 90%)		96%
FOLLOW UP RATE FOR LIVING PATIENTS ONLY (*** should be 80%)	1,771	86%

*Non-analytical, basal and squamous cell cancers of the skin and in-situ of the cervix are excluded from the calculations of follow-up percentage.

2004 TUMOR BOARD REPORT

Our weekly Tumor Board is a conference, which includes both case presentation and a didactic program. Following each presentation, there is an informal discussion of the case and review of the recommended staging and treatment modalities available. This ensures our patients a multi-disciplinary approach to the treatment of their disease as well as providing education to the house staff, students and allied health professionals in attendance.

During 2004, there were 169 presentations (138/82% prospective/18% retrospective) of new primaries, recurrences or follow-ups. Sites presented included: Bladder, brain, breast, colorectal, esophagus, kidney, liver, larynx, limbus of eye, lung, lymphoma, melanoma, nasal cavity, oral cavity, pancreas, pharynx, prostate, thyroid and unknown origin.

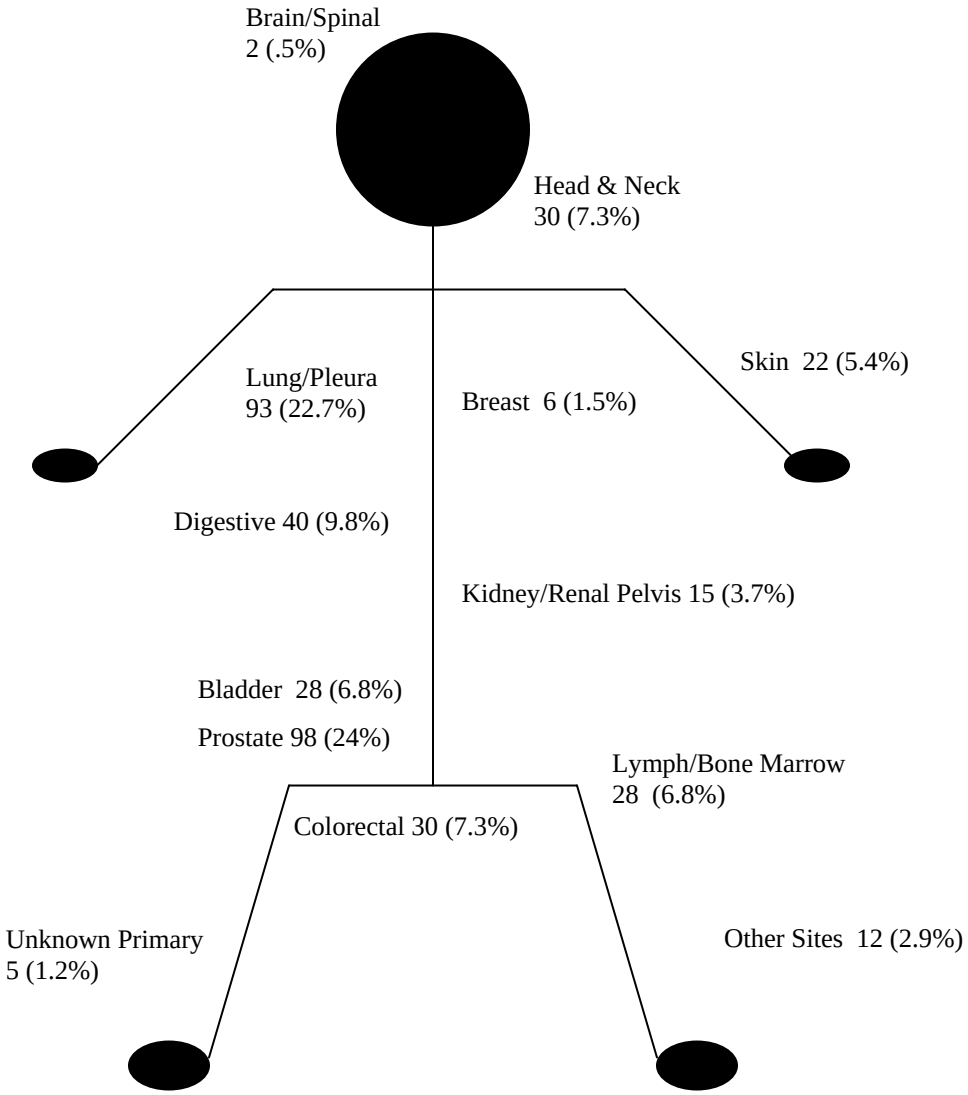
The Stratton VA Medical Center has several oncology related specialty clinics that oversee the ongoing multi-disciplinary care and treatment for various patients. ENT Clinic is held three times a week, seeing approximately 21 cancer patients weekly. GU Clinic sees an average of 18 patients with cancer each week. Medical Oncology Clinic sees approximately 32 patients weekly, and Hematology sees an average of 40 (both malignant and pre-malignant) cancer patients weekly depending on the chemotherapy schedules. Our chemo infusion suite sees and treats approximately 43 patients weekly. Radiation Therapy averages 19-22 veteran treatments per day. Thoracic Surgery Clinic sees approximately 3 cancer patients weekly.

PRIMARY SITE TABLE
2004

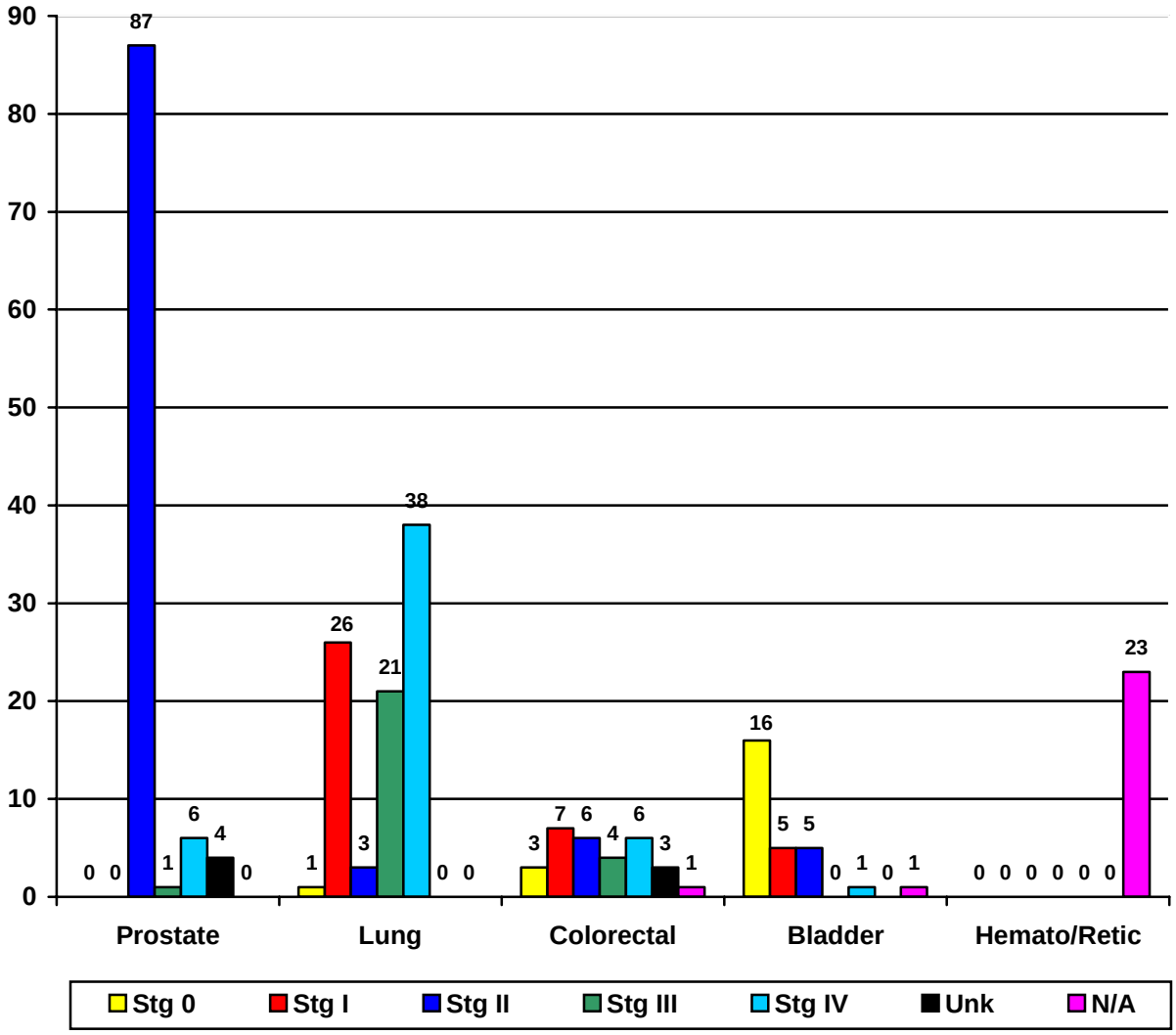
PRIMARY SITE	#	%	CLASS OF CASE		ANALYTIC AJCC STAGE						
			A	NA	0	I	II	III	IV	U	N/A
ALL SITES COMBINED	426	100.0	409	17	42	57	126	50	78	22	34
HEAD & NECK (except Larynx)	21	4.9	21	0	3	3	4	1	10	0	0
DIGESTIVE SYSTEM											
Esophagus	12	2.8	12	0	0	0	2	5	5	0	0
Stomach	6	1.4	4	2	0	0	1	0	3	0	0
Colon	19	4.5	17	2	3	3	2	4	2	3	0
Rectum/Anus	14	3.3	13	1	0	4	4	0	4	0	1
Liver/Biliary	12	2.8	11	1	0	3	2	6	0	0	0
Pancreas	11	2.6	11	0	0	0	6	0	5	0	0
Gallbladder	1	.2	1	0	0	0	0	0	0	1	0
Other Digestive	1	.2	1	0	0	0	0	0	0	0	1
RESPIRATORY SYSTEM											
Accessory Sinuses	1	.2	1	0	0	0	1	0	0	0	0
Larynx	8	1.9	8	0	2	2	1	3	0	0	0
Lung	91	21.4	89	2	1	26	3	21	38	0	0
Pleura	4	.9	4	0	0	1	0	2	0	1	0
SKIN	22	5.2	22	0	11	4	1	1	0	5	0
CONNECTIVE TISSUE	3	.7	3	0	0	0	1	0	0	2	0
BREAST	6	1.4	6	0	1	1	2	1	0	1	0
CERVIX	1	.2	1	0	1	0	0	0	0	0	0
GENITOURINARY ORGANS											
Prostate	102	24.0	98	4	0	0	87	1	6	4	0
Kidney/Renal Pelvis	15	3.5	13	2	0	3	0	3	3	4	0
Bladder	29	6.8	28	1	16	5	5	0	1	0	1
Penis	2	.5	2	0	2	0	0	0	0	0	0
Testis	3	.7	3	0	0	2	1	0	0	0	0
Ureter	2	.5	2	0	2	0	0	0	0	0	0
Other Male (Scrotum)	1	.2	1	0	0	0	1	0	0	0	0
EYE	1	.2	1	0	0	0	0	0	0	1	0
BRAIN/SPINAL CORD	2	.5	2	0	0	0	0	0	0	2	0
THYROID/OTHER ENDO	1	.2	1	0	0	0	0	0	0	1	0
LYMPH NODES	5	1.2	5	0	0	0	2	2	1	0	0
BLOOD & BONE MARROW	24	5.6	23	1	1	0	0	0	0	0	23
UNKNOWN PRIMARY	6	1.4	5	1	0	0	0	0	0	0	5

A=Analytic NA=Non-Analytic U=Unknown N/A=Not Applicable

Cancer Incidence By Primary Site
2004 Analytic Cases – 409



Five Most Frequently Occurring Primary Sites – 2004 Distribution by AJCC Stage Analytical Cases



CANCER PREVENTION AND EARLY DETECTION

WOMEN VETERANS HEALTH PROGRAM

Stratton VA Mammography Program Highlights:

- Number of patients=994 for the time period (7/1/04-6/30/05). Six Breast cancers discovered: #1-DCIS, #2-Grade 3-Infiltrating Ductal Carcinoma In Situ (employee), #3-DCIS,both Lobular & Ductal (Healthy Woman Partnership), #4-Simple Cysts & Infiltrating Ductal Carcinoma with Invasive Component, #5-Lowgrade DCIS & Ductal Hyperplasia, #6-Invasive Ductal Carcinoma with extensive Invasive Component. Twenty-two calls to biopsy: 16 negative cases, all went to biopsy, all tracked by Mammographer thru VA & Private Facility Lab Report Coordination (36% positive in this time frame).

- VA rescreen rates calculated to be 93% VISN2, and Albany 100% rescreen rate, both better than private sector benchmark of 83.1%, per VA Baldridge submission.

- April '05 Correlation of Biopsy data highlights: The following data utilizes the MQSA time frame as given to the Federal Inspector on June 17, 2005. Full detailed report available in the Mammography Unit.
  - Recall Rate-(goal-, <10%) = 10%-Excellent.
  - Cancer found per 1000 patients=5 malignancies found (goal-2-10).
  - PPV1-Positive Predictive Value based on abnormal findings at Screening = (goal-5-10%) = 49%.
  - PPV2-When Surgical, Biopsy (surgical, FNA, Core) recommended = (goal-25-40%) = 24%.
  - Sensitivity-% of cancers detected by mammography-(goal>85%) = 83%.
  - Specificity-% of cancers detected by mammography-(goal>90%) = 98%.

- Seventh Year of Mammography Quality Standards Assurance Program /MQSA/FDA Site Inspection - Pass. One Level Two noted, on missing BIRAD Numeric Code caused inadvertently by VA Secretary (computer error) Prior Six Inspections Perfect Score. Reaccredited to June 2008. VHA Mammogram national publication of the VA in house mammography team cited Albany for it's top level ratings, in December 2004 publication.

- Continued utilization of local associate mammography technology at St. Peters Hospital: Stereotactic Breast Biopsy (4) and MRI of the breast (2). Collaborating to offer the newest technology to our Radiologists, Surgeon and patients. Mammographer at VAMC is the on site coordinator for this program.

- Tenth Year of being a member of The Albany County Healthy Woman Partnership offering no cost mammography to under insured, noninsured low income citizens. Screening & diagnostic mammography, plus ultrasound and clinical breast exams available. Mammographer at VAMC is the on site coordinator for this program.

- Dr. Elizabeth Robison, VA Breast Surgeon, volunteered to be the VA Physician for the Healthy Woman Partnership at the VA Mammography Site.

- VA shared in the Albany County Healthy Woman Partnership's overall success of its screening contract program of 2004-2005 with exceeding goal by 128%! (Goal of 325 patients met by servicing 416 patients) 38 patients received life saving mammography at the Stratton VA Healthy Woman Partnership Program.

- Making Strides Against Breast Cancer October '05 Team had 183 walkers and $32,000 collected, 3rd largest Corporate Team Enrollment!

- The new Biolucent mammography softpad was stocked to decrease patient discomfort and anxiety. To date the D&T care line has collected over 70 positive customer service cards, citing greatly improved positioning and compression. Female veterans are unanimous with private sector patients, that state the Biolucent technology is changing the way mammography is perceived. This item should assist the VA in reaching the American Cancer Society 2006 Line Of Sight Goal #1 of Increasing Mammography Screening from 63% to 75% new patient load. As we know, women exchange medical advice through word of mouth referral. This item is truly changing overall impressions, and enhancing womans' comfort levels in mammography.

The eleventh year of imaging at Stratton VA Mammography Center has been a success thanks to the continued support of so many administrators that listened to its female veteran patients, and mammography team.

Cervical Cancer Screening:

Thin Prep method has been fully implemented for collection of specimens for Pap smear. There were 706 specimens read from July 1, 2004 to June 30, 2005, the most ever at Stratton VAMC cytology lab. All specimens are being obtained in the GYN Clinic setting. Of the 706 specimens: 650 were negative, 31 atypical, 12 low grade, 3 high grade, and 10 unsatisfactory for diagnosis. Follow up occurred for all questionable results, either by repeat pap, colposcopy, or leap procedures.

Quality Care Enhancements:

Stratton VAMC is doing 100% Thin Prep (liquid based cytology) in conjunction with the HPV (Digene Hybrid Capture II HPV test for high risk HVP types). VISN 2 Women Veterans Health Care Council, under the leadership of Kathy Prividera, submitted an Executive Decision Memo (EDM) requesting the approval for VISN wide implementation of ACOG Guidelines (American College of Obstetricians and Gynecologist) for cervical cancer screening.

Women up to age 30 = annual pap. Women age 30 and older have options: (1) women who have had 3 negative results on annual pap tests can be rescreened with cytology alone every 2 to 3 years; (2) annual cytology testing; (3) cytology with the addition of an HPV-DNA test. If both the cervical cytology and the DNA tests are negative, rescreening should occur no sooner than 3 years. * Women of any age who are immunocompromised, are infected with HIV, or were exposed in utero to DES should be screened annually.

VISN 2 Women Veterans Health Care Council (WVHCC) proposed the following:

Category 1: Women <30: receive annual thin prep with reflux to HPV with abnormal results and HPV testing for high risk patients as needed secondary to dysplasia or follow up of dysplasia post treatment.

Category 2: Women >30:
Average risk patients: receive annual thin prep with reflux to HPV with abnormal results and HPV testing for high risk patients as needed secondary to dysplasia or follow up of dysplasia post-treatment.
High risk patients: receive annual thin prep with HPV testing and as needed secondary to dysplasia or follow up of dysplasia post treatment.
Low risk patients: good candidates for triennial Thin Prep PAP with HPV testing and as secondary to dysplasia or follow up of dysplasia post treatment.
Patients that are not compliant with yearly PAPS and want to increase intervals between PAP smears and are not high risk: good candidates for triennial Thin Prep PAP with HPV testing and as secondary to dysplasia or follow up of dysplasia post treatment.

Patients who are being deployed for a long period of potentially more than one year: HPV along with Thin Prep and as needed secondary to dysplasia or follow up of dysplasia post treatment.

As a result of this progressive work in VISN 2, Kathy Prividera, member of the National Field Advisory Women Veterans Health Program, CO, was appointed to a task group charged with drafting an informational letter on cervical cancer screening. The draft was presented to the Undersecretary for his signature.

Microbiology laboratory, under the direction of Dr. Mary George, now offers amplified nucleic acid testing for Chlamydia trachomatis and Neisseria gonorrhoeae. This sensitive technique allows for the use of urine samples, for the detection of these two agents of sexually transmitted disease.

The National Women Veterans Plan of Care and Clinical Inventory were completed. Services not available at CBOCs or in house are fee based to the community. The availability of Behavioral Health providers with in primary care settings is a valuable asset.

The integrated CPRS/Women's Health software was released to the field for installation. This has been a six year national task group which Ms. Prividera has been a project member for design and development. This software has the ability for radiology and cytology results when entered, to activate a second clinical reminder to alert the provider the exam has been completed and report is available. This is a double safety check to eliminate missed abnormals requiring follow up actions.

Stratton VAMC has been one of four intervention sites nationally for Project H.O.M.E. (Healthy Outlook on the Mammography Experience) dissemination grant based out of the University of Texas. From December 2004 to May 2005, educational packets were mailed to the Women Veterans Program Manager (WVPM) for distribution to women age 35 and over. The packets contained four booklets and a letter under the signature of the WVPM. The booklets were designed as (1) Precontemplation: What's Mammography All About? (2) Contemplation: The Mammography Choice: Is It for Me? (3) Action: Developing the Mammography Habit (4) Maintenance: Keeping Up the Mammography Habit. Several bookmark reminders were also included. These were initially distributed to women during their annual GYN visit. Distribution was later extended to primary care and associated CBOCs.

Stratton VAMC strives to be progressive with women's health and address the younger veteran as she presents with various health needs. Extensive out reach and education in the community and to reserve and guard units has been in conjunction with the Veteran Service Center Staff.

CANCER CARE AND SUPPORT SERVICES

CHAPLAIN SERVICE

Patient contacts occur in the course of intentional spiritual care visits, casual supportive conversation, sacramental ministrations, and in worship services. The Chaplain goal is to foster in the patient a spirit of hope and confidence that enhances the benefits of medical care, as well as enabling the patient to cope with the fragility and uncertainty of life.

CONTINUUM OF CARE - Chaplain Service has the unique opportunity of providing spiritual care and emotional support to oncology patients regardless of their movement among various wards and clinics, or the frequency of admissions. In the course of daily visits upon all Critical Care Unit patients, all new admissions, and surgical patients, a meaningful spiritual care relationship often develops. This continuum of care extends through the various stages of treatment, to life and death decision-making and bereavement support for family.

END-OF-LIFE PLANNING - Chaplains track patients with end-of-life related diagnoses such as cancer. In addition to referral information from the Advanced Illness Coordinated Care Program it is most helpful when the attending physician or nurse alerts us to a focused and immediate need in regard to a poor prognosis subsequent to biopsy or surgery. This permits timely spiritual and emotional support for both family and patient.

PALLIATIVE CARE PROGRAM - Chaplains participate in the interdisciplinary care plan of the Palliative Care Unit (PCU) by means of interdisciplinary patient review meetings, and providing regular spiritual care visits upon all PCU patients. As staffing hours permit, we seek to render spiritual care support to families, often including bedside prayers of commendation to God upon the patient's death. A chaplain always participates in the periodic memorial services conducted by PCU staff.

BEREAVEMENT SERVICES – In addition to availability to families at time of a patient’s death, a letter of sympathy, over the Director’s signature, is sent to all next of kin of deceased veterans enrolled in VAMC. This letter includes announcement of our semi-annual non-denominational “Roll Call and Remembrance” memorial service for all Veterans (Sundays before Memorial Day and following Veterans Day). Also, the chaplain unit anticipates the possibility of an annual memorial service initiated by the Oncology Unit, and is prepared to be supportive of that program.

CANCER SURVIVORS CELEBRATION - Chaplain Service continues to play a supportive role at this annual program.

DENTAL SERVICE CANCER PROGRAM

The Stratton VA Medical Center Dental Service plays an integral role in the management of head and neck cancer patients. The three primary objectives of the Dental Service Cancer Program are:

(1) To participate fully in patient assessment and interdisciplinary treatment planning.

(2) To establish optimum oral conditions for tumor therapy management.

(3) To maintain effective recall for follow-up care of these patients.

On admission to the hospital, all suspected head and neck cancer patients are to be referred by consultation to the Dental Service. Such referral is to be made also for patients referred to Radiation Therapy for irradiation of the head and neck. Each patient is assessed on an individual basis in regard to overall systemic health, tumor prognosis, oral health and motivation in order to develop a dental treatment plan which can be well integrated into the overall treatment plan (surgery, radiation and/or chemotherapy).

Early involvement of the Dental Service for evaluation and proper timing of any necessary dental treatment will provide appropriate integration of medical/dental care, reduce management complications, and best serve the health and welfare of the patients involved.

All patients are instructed in proper oral hygiene. Radiation patients are placed on a fluoride therapy protocol and are seen during radiation therapy to screen for any untoward oral sequelae such as mucositis, xerostomia, loss of taste, and radiation caries. Patients who experience any oral sequelae to radiation therapy are appointed for follow-up on a long term basis. In light of this stringent follow-up program, very few cases of osteoradionecrosis have been reported at this center.

Any acute dental problems are best treated prior to surgical, radiation or chemotherapy treatment. Routine dental treatment is reinstituted once the patient is ambulatory and comfortable following surgery, radiation and/or chemotherapy.

By assessing each patient in the pre-treatment phase, any necessary post-treatment prosthetic rehabilitation is facilitated, be it in the form of intraoral obturators, specialized prostheses such as tongue bulbs or extra-oral facial prostheses.

A survey was conducted of the head and neck cancer patients identified during the 2004 calendar year based on data obtained from the Stratton VA Medical Center Tumor Registry. The purpose of this survey was to determine the percentage of patients identified with head and neck cancer that were screened, treated and/or followed by the Dental Service.

Thirty-one of thirty-four patients were seen by Dental Service. Of the three patients not seen: Two patients refused to keep their appointment for Dental Service Consultation: One had a supraglottic laryngeal carcinoma while the second had a pyriform sinus lesion. Both patients passed away with in four months of diagnoses. A third patient received radiation therapy for a T2N0M0 laryngeal carcinoma and was never referred by Radiation Therapy for consultation

The rate of examination of head and neck cancer patients is lower with the introduction of computerization in health care and reduction in staffing hospital wide. We no longer manually check lists such as ward admission diagnoses and operating room schedules. Instead, we rely on consultations generated by the Head and Neck Pathway. The referring services send these patients to Dental Service for supportive care on a prn basis. Dental Service is represented at Tumor Board; consultations do get generated on newly identified patients.

The reduced staffing problems of the Dental Service contribute to the challenge of seeing every identified head and neck cancer patient. An interdisciplinary continuous quality improvement team had developed a Head and Neck Clinical Pathway to insure timely notification and consultation with respective services. However, this pathway is set to notify us on presentation of a T2 or greater lesion, but not with a T1 lesion. We also depend upon ENT to set the clinical pathway in motion.

In short our examination rate of head and neck cancer patients has been as follows:

Calendar Year	1995	33/37	89%
	1996	44/48	92%
	1997	34/37	92%
	1998	19/26	73%
	1999	29/35	83%
	2000	29/34	85%
	2001	28/33	85%
	2002	31/35	89%
	2003	32/35	91%
	2004	31/34	91%

The data was integrated into the table developed last year for an overview of patients identified and screened during 1983-2004. The data reflects very well the interdisciplinary approach of management of head and neck cancer patients. Tables have also been developed to illustrate the numbers of patients diagnosed by site at the Stratton VA and numbers of these patients screened and/or treated by Dental Service during 1983-2004. The Stratton VA Medical Center Dental Service does indeed play an integral role in the treatment of such patients.

HEAD AND NECK CANCER PATIENTS 1983-2004

Tumor Site	Number of Patient Identified	Number of Patients seen by Dental Svc.	Patients seen by Dental Svc.
Tongue	142	129	90.8
Salivary Glands	13	9	69.2
Gingiva	13	13	100.
Floor of Mouth	87	82	94.2
Other Mouth	85	78	91.7
Oropharynx	129	123	95.3
Nasopharynx	30	28	93.3
Hypopharynx	103	95	92.2
Nasal Cavity	29	27	93.1
Larynx	342	303	88.6
TOTAL	**973**	**887**	**91.2%**

HEAD AND NECK CANCER PATIENTS
SCREENED AND/OR TREATED BY DENTAL SERVICE
1983-2004

	1983-87	1988-92	1993-97	1998-02	2003	2004
TONGUE	39	31	30	25	6	4
SALIVARY GLANDS	0	9	0	0	0	0
GINGIVA	1	5	2	4	0	1
F.O.M.	24	22	20	13	1	3
OTHER MOUTH	27	18	14	14	5	5
OROPHARYNX	21	38	28	29	7	7
NASOPHARYNX	6	11	4	5	3	2
HYPOPHARYNX	35	25	26	11	3	0
NASAL CAVITY SINUSES	6	13	2	4	1	2
LARYNX	77	86	70	63	6	7
TOTAL	**236**	**258**	**196**	**168**	**32**	**31**

HEAD AND NECK CANCER PATIENTS
1983-2004
INCIDENCE BY SITE

	1983-87	1988-92	1993-97	1998-02	2003	2004
TONGUE	41	35	33	29	6	4
SALIVARY GLANDS	0	13	0	0	0	0
GINGIVA	1	5	2	4	0	1
FOM	25	22	22	15	1	3
OTHER MOUTH	27	21	15	17	5	5
OROPHARYNX	23	39	29	31	7	7
NASO-PHARYNX	6	11	4	8	3	2
HYPO-PHARYNX	36	25	27	14	3	1
NASAL CAVITY SINUSES	6	15	2	4	1	2
LARYNX	89	90	77	77	9	9
TOTAL	**254**	**276**	**211**	**198**	**35**	**34**

ENTEROSTOMAL THERAPY

The scope of practice of the enterostomal therapist includes functioning as a professional nurse for patients with fecal or urinary diversions, wounds, drains, pressure ulcers and incontinence. This includes acute care, rehabilitation and patient/caretaker teaching and counseling. Educational opportunities are provided to staff and patients.

The therapist initiates and provides ongoing evaluation of patient care management of all patients with stomas and those anticipating ostomy surgery. The therapist also provides care to patients with head and neck cancer who have G-tubes placed for feeding.

HEMATOLOGY/MEDICAL ONCOLOGY REPORT

The Hematology/Medical Oncology Staff is comprised of three full-time physicians, one part-time physician, one full-time PA, three full-time RNs, one part-time RN, one full-time LPN and one Research Study Coordinator. Nurses are available on a rotating schedule to meet the treatment needs of patients on the weekend. Hematology/Oncology nurses serve as a resource for other nursing staff in the inpatient, outpatient and community arenas.

The Comprehensive Center for Cancer and Blood Disorders is now located on the 9th floor, A wing. The new area allows for patients and families to have all facets of care managed in one area (i.e., physician, nursing, pharmacy, dietitian, Advanced Illness Care Coordinator (AICC) and social worker). Eight (8) exams rooms are available for physicians to meet with patients and family. A conference room is available on the unit, as well as a counseling room directly adjacent to the unit.

The Infusion Suite and Chemotherapy mixing room are located next to each other with a pass through area for drug delivery. The suite is open Monday through Friday. It is a nurse-managed area with physician coverage as needed. There is capacity for 12 patients to be treated at any given time (10 treatment chairs and 2 beds) depending on patient needs. There is a nourishment kitchen located in the suite, enabling patients to have snacks, coffee, and juices during their treatment. Lunch is provided for patients receiving treatment.

The responsibilities of the Hematology/Oncology Nurses include:

- Teaching of patients and their care givers in the disease process and treatment plan.
- Enabling patients to cope with symptoms of their disease and side effects of their therapy.
- Safe administration of cytotoxic therapies & monoclonal antibodies.
- Administration of blood and blood products.
- Administration of all outpatient infusions for all services throughout the hospital such as Rheumatology and Neurology.

When appropriate, patients and their significant others are taught the procedures for administration of injections, biological response modifiers and growth factors. This enables them to care for themselves at home; therefore, leading a more normal life.

From 7/01/04 to 6/30/05 there were a total of 5939 encounters. This shows a decrease of 197 visits over last year's 6,136. Changes in provider staffing; more oral agents prescribed to be taken at home; and changes in treatment modalities requiring fewer visits have contributed to this decrease.

NUTRITION AND FOOD SERVICE

Nutrition and Food Service provides an extensive program to meet the oncology patient nutritional needs. Food service is provided to patients with Cancer at various sites including an outpatient dining room, Medical and Surgical wards, Geriatric Evaluation Unit, Outpatient Oncology Clinics, and Hospice.

If a patient develops problems with their nutritional intake while lodging on the premises for ongoing treatment, a consult to the Outpatient Oncology Dietitian can be made. Frequently, adjustments are made in the consistency of foods available in the Dining Room, i.e. softer foods or more liquids that will assist patients in maintaining their food intake. Nutritional supplements, ice cream, and various entrée choices are also available for these patients to enhance calorie and protein intake.

Lunch is provided for patients undergoing treatment in Hematology/Oncology/Infusion Suite. This is necessary to provide adequate nutrition to support infusion therapy treatments of these patients.

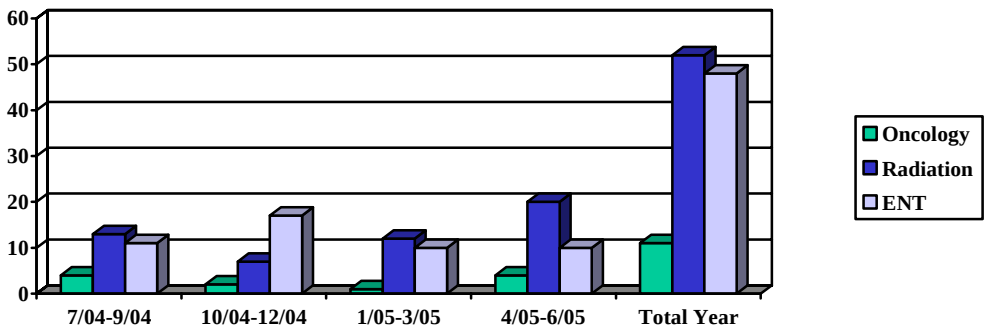
The Nutrition Service provided assessment and counseling to 111 Outpatient Oncology Clinic patients on a consult basis from 7/1/04 to 6/30/05. Of the 111 patients 48 were Head and Neck Cancer patients, 11 patients were receiving chemotherapy treatment and 52 were receiving radiation therapy. These patients required assessment and counseling due to weight loss , risk for having compromised nutritional intake, and/or patients requiring nutritional supplements (tube feeding or by mouth) for more the 30 days.(See Graphic Chart.) Counselling sessions include self management educational materials pertinent to specific symptom management to minimize weight loss.

Nutrition services are provided to Hospice as needed. The nutritional emphasis is on providing comfort to these patients.

Nutritional evaluation of status and risk is routinely provided for hospitalized patients including oncology patients. Patients that are at nutritional risk receive a comprehensive nutritional assessment. Patients with low albumin levels, low Body Mass Index, NPO or receiving nutritional support are considered to be at risk of nutritional compromise.

During Nutrition Month this year, informational displays in the Comprehensive Cancer Care Center and the hospital lobby emphasized the changes in the Dietary Guidelines for Americans 2005. These displays provided information on the benefits of increasing fruits and vegetables and whole grains intake which are two of the American Cancer Society Recommendations from *Nutrition and Physical Activity for Cancer Prevention*. The Dietary Guidelines for Americans 2005 were also included in 2005 version of the *Guide to Cancer Care Resources and Services* booklet distributed at the Stratton VA Medical Center Cancer Survivors Day celebration.

Outpatient Nutritional Counseling for Cancer Patients
7/01/04 - 6/30/05



ADVANCED ILLNESS COORDINATED CARE / PALLIATIVE CARE CONSULT TEAM

The Advanced Illness Care Coordination program is available to all veterans who are diagnosed with an advanced illness. This includes; cancer, end stage renal disease, HIV/AIDS, CHF, COPD and dementia. The goals of this program are to;

- Provide psychosocial supplement to physician and medical team's care.
- Help patient get necessary information about illness and provide guidance on treatment.
- Facilitate end of life conversations, advance care planning and care coordination.
- Help veterans prepare and plan earlier rather than later in the disease process.
- Provide patient centered care that empowers patient to maintain control and dignity through the disease process.
- In summary, the program helps patients to get information on their illness and treatment available, make choices when it comes to types of care, and assisting patients and families to cope with advanced illness.

Consults are entered electronically and responded to by Advanced Illness Care Coordinator. They may be entered by any discipline. Data from 8/04-8/05 showed a 21.6% increase in consults.

If the veteran is in need of palliative care, the Advanced Illness/Palliative Care Coordinator has a team of physicians, social worker and chaplain to collaborate with. This team is available on a consult basis to provide symptom and pain management, psychosocial support and help with advance planning to our veterans with advancing illness who are no longer seeking curative treatment.

PALLIATIVE/HOSPICE CARE PROGRAM Review
FY 05-(10/04-5/23/05)

Program Mission: The mission of the inpatient Palliative Care/Hospice Program is to provide hospice services to terminally ill veterans and families. The program emphasizes the management of pain and other physical symptoms. The program minimizes aggressive and /or invasive treatments and/or life sustaining measures, which do not contribute to patient comfort or an improved quality of life.

Scope: Since it's inception in April 1986, the inpatient palliative care/hospice program has provided palliative/hospice services to terminally ill veterans. Providing palliative/hospice care presents new challenges, unique problems and opportunities to grow and learn from our patients and families.

On going analysis of the program has demonstrated that the needs of terminally ill veterans and their families can be met on an inpatient unit by an interdisciplinary team providing care. The interdisciplinary team is fundamental to palliative/hospice care. Interdisciplinary (as opposed to multidisciplinary) implies that the team members do not work in isolation, but blend through an ongoing team process with the primary emphasis on treating the veteran and family as one unit of care.

General admission criteria:

- Eligibility for VA services
- A life expectancy measured in weeks- 3 months, not years
- A willingness to forgo extraordinary and artificial life support measures which may prolong life with no regard to quality of life
- An understanding and acceptance of hospice on the part of the patient (and family) and a desire for support and assistance in maintaining a natural and comfortable quality of life.

Staffing: Currently no designated FTEE for this program. All collateral staff.

Core staff consists of:

- Sandra Osborne RN- Program Coordinator
- Nancy Jane Batten NP
- Nick Tebordo - Chp
- Gina Smith - SW
- Rachelle Vishneowski - MT
- Nancy Nelson-RN-AICC

Workload:

Uniques Treated	
FY 05 10/04-5/23/05	35
FY 04	56
FY 03	38
FY 02	45
FY 01	42
FY 00	53

The inpatient core team has hosted two memorial services thus far this FY (05):

- 11/04/04 - 21 family members attended
- 05/19/05 - 28 family members attended

Admissions per month 3rd Qtr FY04 to present:

- 2004: 10/04=6 11/04=5 12/04=2
- 2005: 01/05=4 02/05=3 03/05=5 04/05=6 05/23/05=4

Average LOS = 24 days

- 3 patients had LOS > 60 days
- 1 patient had LOS of 90 days
- 11 patients had LOS < 7 days

There were 124 deaths in the hospital from 10/04-5/23/05 and 30 of them occurred in hospice 25%.

Received 49 (10/04-5/23/05) referrals for inpatient services 71% of those referred were admitted.

14 veterans not admitted for various reasons, which include:

- no available inpt bed and vet died on acute-1
- vet/family refused inpt palliative/hospice care-6
- vet actively dying when assessed by team-5
- medical work up was not complete-2

Mean days to complete a consult was 2.73.

Major Diagnosis of Veterans Treated	
Lung Ca	14
Renal Cell Ca	5
Prostate Ca	4
CHF	4
CVA	2
Oral Ca	2
End Stage Hepatic Disease	2

Other diagnoses treated include: brain tumors, thymic carcinoma, end stage diabetes insipidus, dementia, colon ca, gastric ca, and multiple myeloma.

Donations: Received $850.00 in donation so far this Fiscal Year.

Accomplishments: The core team was nominated for the Distinguished Federal Government Service- Team Award.

Inservice: Veterans at the End of Life: Meeting the Challenge presenters Sandra Osborne and Gina Nunziato-Smith on 5/3/05 1:30-3:30 audience- community hospice interdisciplinary staff.

Developed an insert for community hospice to use in their flyer.

Goals:

- Continue to promote end of life care.
  Advocate for VA end of life care, VA/Community Hospice Partnership- PCCT, ongoing education-for team and staff.

- To maintain the cohesiveness of the core palliative/hospice interdisciplinary team.
  Continue weekly team meetings.
  Foster flexibility and creativity in providing hospice care.
  To develop/mentor one staff nurse to carry out the philosophy and be a part of the core team

SOCIAL WORK SERVICES

The primary focus of the Oncology/Hematology Social Worker is to provide psychosocial support and resource information to patients and families facing the challenge of cancer. Many of the cancer patients treated in our institution have been served by social work. Patients and families are offered psychosocial support as they receive diagnosis and treatment. They are also assisted in obtaining appropriate in-home and community services to enhance their quality of life.

Participation on the Advanced Illness/Fair Care team continues. Emphasis is focused on providing patients and families with supportive counseling and assistance with concrete, practical issues that arise in the last phases of life, such as legal and financial concerns. This team responds to formal referrals of patients and families who are facing an advanced illness and would benefit from increased support and assistance. Many of the patients referred to this program have been recently diagnosed and/or are living with cancer. This program provides patients with support, guidance and end of life planning, if necessary.

The Oncology Social Worker assists patients to meet the challenges faced with End of Life Planning. Advanced Directives are discussed with new Oncology and Radiation Therapy patients. Paperwork is provided and completed, when patient and family are prepared to do so. Furthermore, assistance and linkage with available VA and community resources for those facing the imminent death of a loved one and/or resources for those who have recently lost a loved one is available to patients via the Oncology Social Worker. Linkage with Certified Home Care Hospice programs appeared to be especially helpful. Ongoing social work involvement ensures the continuity of care in the provision of outpatient, inpatient, transitional and Hospice Services.

SPEECH PATHOLOGY

Cancer patients are provided assessments, treatment and education/counseling regarding the potential impairments in swallowing and/or communication (language, speech, voice and/or cognition). These may occur as a result of the cancer and/or subsequent treatments. Services are provided throughout the continuum of care and vary based on treatment options.

Twenty-eight per cent of patients referred to speech pathology, had a diagnosis of cancer. One quarter of these received their primary care at other VA sites but came to the Albany VA for Radiation Oncology or Otolaryngology services with subsequent speech pathology referrals. Forty-three percent of the cancer patients were seen for swallowing intervention; 12 percent for communication work ups and 45% for both communication and swallowing issues. Seventy-one percent of the cancer referrals were head and neck sites which included: tongue, nasopharynx, retromolar trigone region, floor of mouth, larynx (glottic and supraglottic areas) and mandible. These patients are the most likely to have impairments in swallowing, speech and/or voice. Patients with other primary sites are usually referred due to dysphagias resulting from multiple co-morbidity issues. Other sites included: brain, lung, stomach, esophagus and prostate.

One total laryngectomy was done in Albany. Five additional laryngectomees were referred to speech pathology for communication issues related to alaryngeal speech production (electrolarynx or Tracheoesophageal Puncture TEP). There are 15 active TEP patients seen on an "as needed" basis for changing of the voice prosthesis and for ordering related supplies. Troubleshooting of difficulties related to TEP is done in conjunction with Otolaryngology Clinic.

Swallowing problems frequently persist in the head and neck population. The extent of the dysphagia depends on the site/location, extent of treatment and patient's ability to cope and adjust to the changes. Of these patients, 5% returned to a normal diet, 42% took a modified texture diet usually with oral nutritional supplements, 25% obtained most nutrition through non-oral means but did take limited oral feedings for pleasure and 28% took nothing by mouth.

The persistent dysphagia in the head and neck cancer population has been addressed by Speech Pathology, Otolaryngology and Thoracic Surgery. Esophageal dilatation has been completed on 4 patients. All were 2-10 years post radiation/chemo radiation changes for supraglottic, base of tongue or pyriform sinus tumors. Fifty percent had surgical resection as well. Three patients were nonoral due to absent or nonfunctional swallow. One patient took a modified textured diet. All have noted improvement in swallowing function since the procedure. Two have progressed so significantly they have had their feeding tubes removed. Additional candidates are now being considered for esophageal dilation.

DIAGNOSTIC PROCEDURES AND TREATMENT FOR CANCER PATIENTS

NUCLEAR MEDICINE

1. Between 7//1/04 through 6/30/05 a total of 111 cancer patients visited Nuclear Medicine Service with 3 I-131 therapies for thyroid cancer, 1 Strontium therapy and 107 diagnostic procedures were performed (please refer to Table 1 and Table 2 for details).

2. The cancer patients, as well as, researchers can benefit a great deal from the amazing advances in instrumentation and pharmaceuticals in the field of Nuclear Medicine. At this medical center with present equipment, we are able to perform most of these procedures.

DIAGNOSTIC PROCEDURES
Table 1

TESTS	PATIENTS
Bone densitometry	1
Bone Scan	93
Ejection fraction	7
Gallium	1
I-131 total body scan for thyroid cancer	3
Hemangioma	1
GI bleed	1
Ventilation/perfusion	3

THERAPEUTIC PROCEDURES
Table 2

TESTS	PATIENTS
Quadramet therapy	0
Strontium 89 therapy	1

TOTAL = 111

ONCOLOGY CLINICAL RESEARCH

The Oncology Research Program has continued to follow patients previously enrolled in two cancer prevention trial, SELECT (24) and PIVOT (27). In addition to these studies one patient continues to be followed for survival for the RP56976-V-TAX 326 protocol.

We have been accepted as an affiliate member of the Cancer and Leukemia Group B (CALGB).

The following studies remain open for follow up only:

VA COOPERATIVE GROUP STUDIES

Protocol #	Title
407	Prostate Cancer Intervention Versus Observation Trial (PIVOT): A Randomized Trial Comparing Radical Prostatectomy Versus Palliative Expectant Management for the Treatment of Clinically Localized Prostate Cancer
499	S0000: Selenium and Vitamin E Cancer Prevention Trial (SELECT)

PHARMACEUTICAL STUDIES

Protocol #	Title
RP56976-V TAX 326	A Multi-Center, Multinational Randomized Phase III Study of Docetaxel RP56976, Taxotere) Plus Cisplatin Vs. Docetaxel Plus Carboplatin Versus Vinorelbine Plus Cisplatin in Chemotherapy-Native Patients with Unresectable Locally Advanced and/or Recurrent Stage IIIb or Metastatic (Stage IV)Non-Small Cell Lung Cancer

The following studies were terminated:

PHARMACEUTICAL STUDIES

Protocol #	Title
RP56976-TAX 322	A Randomized, Phase II/III Multicenter Trial of Docetaxel Taxotere®) Plus Cisplatin and Docetaxel Plus 5-FU Versus Cisplatin Plus 5-FU in the First Line Treatment of Patients with Recurrent and/or Metastatic Squamous Cell Carcinoma of the Head and Neck
RP56976-TAX 324	A Randomized, Phase III, Multicenter Trail of Neoadjuvant Docetaxel (Taxotere®) Plus Cisplatin and 5-Fluorouracil (TPF) Versus Neoadjuvant Cisplatin Plus 5-Fluorouracil Followed by Concomitant Chemo-radiology to Improve the Overall Survival and Progression Free Survival in Patients with Locally Advanced Squamous Cell Carcinoma of the Head and Neck
SR96669 EFC 4584	A Multicenter, Open-Label, Randomized Study of 5-Fluorouracil(5-FU)and Leucovorin (LV) or Oxaliplatin or a Combination of 5-FU-LV + Oxaliplatin as Second-Line Treatment of Metastatic Colorectal Carcinoma
SR96669 EFC 4585	A Multicenter, Open-Label, Randomized, Two-Arm Study Of Irinotecan (CPT-11) Vs the Combination of Oxaliplatin + Irinotecan (CPT-11) as Second-Line Treatment of Metastatic Colorectal Carcinoma (MCRC)
AVF2107g	A Phase III, Multicenter, Randomized, Active-Controlled Clinical Trial to Evaluate the Efficacy and Safety of rhuMAb VEGF (BEVACIZUMAB), in Combination with Standard Chemotherapy in Subjects with Metastatic Colorectal Cancer
AVF2192g	A Phase II, Multicenter, Double-Blind, Randomized, Active-Controlled Clinical Trial to Evaluate the Efficacy and Safety of rhuMAb VEGF, A Recombinant Humanized Monoclonal Antibody to Vascular Endothelial Growth Factor, In Combination with 5-Fluorouracil and Leucovorin Chemotherapy in Subjects With Metastatic Colorectal Cancer who are not Optimal Candidates for First-Line CPT-11

The following studies have been approved and actively recruiting:

PHARMACEUTICAL STUDIES

Protocol #	**Title**
Protocol 100988	A Phase II Study of Weekly Topotecan as Second Line Therapy for Small Cell Lung Cancer
Berlex ECO-1	A Phase II Study Using Alemtuzumab combined With Fludarabine for the Treatment of Relapsed/Refractory B-Cell Chronic Lymphocytic Leukemia

Information regarding clinical trials is available by calling:

Stratton VAMC	Lisa Ball, CCRP 626-6447
American Cancer Society	1-800-4-CANCER

PERFORMANCE MANAGEMENT

"Our Medical Center's Mission is to Care for our Veterans with Compassion and Excellence. Our Vision is to be the Health Care Provider of Choice, achieving the highest Quality in Health Care Delivery, Education, and Research. We are committed to adding value to our mission by modeling our Core Values: Trust, Respect, Commitment, Compassion, and Excellence".

Quality and appropriateness of care rendered to oncology patients is reviewed using the following criteria:

Occurrence Screening
Management of care
Utilization review criteria
Patient Safety/Risk Management
Performance Measures

Each case, meeting at least one of the criteria, was subjected to clinical review, root cause analysis, and/or peer review as appropriate. Root Cause Analysis identifies basic reasons that cause or contribute to an adverse event or close call. The analysis focuses primarily on process design and organizational changes. Completed review requires lessons learned action plans, completion dates, and outcome measurement strategies.

The Tissue & Procedure Committee conducts annual tissue and procedure appropriateness reviews. Oncology related issues include bone marrow, bronchoscopy, colonoscopy, colon resection, endoscopic biopsy, or resection of bladder lesions, laryngectomy, and open thoracotomy with lung resection, radical neck dissection, and TURP. The Committee also does surgical case reviews in which positive margins are reviewed for follow up.

Hospital wide monitors, which include oncology patients within the scope of review, include autopsy review, blood usage evaluation, drug usage evaluation, infection control, medical record review, morbidity and mortality review, patient incident review, and pharmacy & therapeutics review inclusive of adverse drug reactions. In all primary care clinics, patients aged 50-69 years, who are eligible, receive education on the risks and benefits of prostate screening. During July 2004 – June 2005 85.2% of those patients who met criteria, received education.

All Care/Service Lines involved in the treatment of oncology patients have systematic processes in place to measure the quality and appropriateness of care. The VA is involved in a nationwide External Peer Review Process. This process provides a national VA database for comparison to national standards in primary prevention and early detection of breast, cervix, and colon cancer. Patient encounters are selected for review monthly by VAMC software. The Hospital wide monitoring through EPRP review includes Primary Care Clinics in-house and some CBOCs. The reviewed timeframe covers July 2004 through June 2005. The results are as follows:

Colorectal Screening- 280 charts reviewed, patients age 50 and older who did not refuse colorectal screening/ 200 charts, a of total 72%.

Cervical Cancer Screening- 50 charts reviewed–female patients age 50 through 69 who were not excluded due to previous hysterectomy and who did not refuse screening. Those screened for cervical caner by Pap test, charts reviewed 44, a total of 89.3%.

Breast Cancer Screening – 59 charts reviewed, female patients age 50-60 who were not excluded due to previous bilateral mastectomy and who did not refuse screening. Patients received a Mammogram for breast screening, 52 charts reviewed, a total of 89%.

In addition, End of Life Planning and Palliative Care for cancer patients are reviewed.

Process improvement plans are in place for preventive indicators.

The Tumor Registry tracks the timeliness of treatment plans after an initial diagnosis of cancer using guidelines established by the American College of Surgeons Commission on Cancer. All adverse events and close calls are forwarded to the Risk Manager. The reviewed timeframe covers July 2004 through June 2005. Three (3) cases were identified. The results are as follows: Two (2) cases were defined as Usual Customary & Reasonable. One (1) case Resulted as a Level 1, in which most practitioners would handle the case similarly.

PHARMACY SERVICE

Pharmacy Service continues to be an integral part of the oncology care team. Pharmacists within the clinical pharmacy section serve as an authoritative information source on antineoplastic drugs, including proper dispensing techniques, preparation, and utilization in therapies. The clinical pharmacy specialists evaluate the current professional literature for analysis of experimental design and conclusions, in order to compare and contrast therapeutic regimens and uses for antineoplastic therapy as well as those therapies required to palliate neoplastic disease related syndromes/symptoms. In addition, the clinical pharmacy specialists design antineoplastic dosage regimens utilizing pharmacokinetic and pharmacy practice standards and specific patient parameters when requested by the attending physicians. The clinical pharmacists design, conduct, and participate in studies, audits, and evaluations concerning the utilization review of antineoplastic drugs, under the auspices of the Therapeutic Agents and Pharmacy Review Committee, Quality Assurance, and Research and Development Committee.

Members of our clinical pharmacy department continue to be active in research follow up and have been recognized for several publications and national presentations. Currently, the Oncology Pharmacy staff consists of a fulltime Clinical Oncology Pharmacist and a part-time Oncology Pharmacy technician. In addition, there is a Research Pharmacist who devotes a significant amount of his time to Clinical Cancer Research Trials and their follow up.

In August of 2004, Sarah L. Scarpace, Pharm.D., R.Ph, Assistant Professor of Pharmacy Practice, Oncology, at Albany College of Pharmacy (ACP) joined the Cancer Center team to provide various educational and support services to the patients and clinical staff. Sarah and students in the final year of the Pharm.D. program from ACP provide patient counseling in the oncology infusion suite on new chemotherapy/targeted therapies and outpatient medications. Patients who are seen by Sarah or the students receive medication lists to carry in their wallet which specifically detail prescription medications, chemotherapy, over-the-counter medications, and complementary alternative medicines and drug allergies. Patients who are prescribed a new chemotherapy regimen are counseled on the drug therapies and related supportive care medications and receive a treatment calendar to help keep track of their therapies. Sarah and the students are actively involved in monitoring drug therapies for efficacy, side effects, and drug interactions and regularly make recommendations to providers to better optimize drug therapy. Sarah and the students also provide educational in-services at the weekly team meetings and occasionally to the tumor board, as well as hold a weekly journal club and provide drug information for the clinical staff. Between November 2004 and June 2005, 8 pharmacy students and 2 pharmacy residents have rotated through the cancer center.

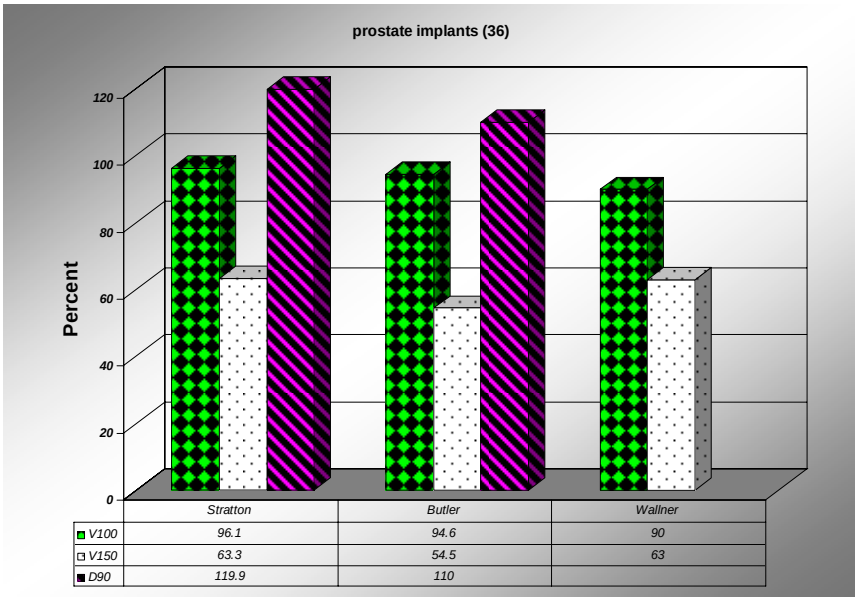
RADIATION ONCOLOGY

The Department of Radiation Oncology is proud to have the distinction of being the VISN 2 Center of Excellence for Radiation Oncology. Referrals are received from within VISN 2 as well from many other VA Medical Centers in the northeast region including the VA's at Castle Point NY, White River Junction VT, Northampton MA, and Wilkes-Barre PA. Referrals for radiosurgery have come from as far away as Lexington, KY. 192 patients have been treated over the past year. 56% of patients were treated definitely and 44% were treated with palliative intent. 55% of the patients treated were referred from the Albany VA, 27% from Syracuse VA and the remainder of the patients were from the Bath, Buffalo, Canandaigua, Castle Point/Montrose, Northampton, Lexington and White River Junction VAMC's.

The center has state-of-the-art treatment and planning equipment and houses the only Stereotactic Radiosurgery and IMRT (Intensity Modulated Radiation Therapy) programs in the VA system in the entire Northeast region. The Radiosurgery/IMRT program opened in April of 2000 and a multitude of disease entities have been treated since that time. Patients who are referred for RT are always considered for Radiosurgery or IMRT if deemed appropriate.

Regionally renowned board certified and/or board eligible Radiation Oncologists provide expert treatment that is delivered with the highest of standards that match or exceed the standards of the cancer care in the community.

In March of 2004 we treated our first patient with our on-site brachytherapy program. This program requires the dedication and collaboration among staff from the departments of Radiation Oncology, Operating Room, the Urology staff as well as the radiation safety officer. Brachytherapy enhances quality patient care while providing great benefit and convenience for our veterans with prostate cancer. Over the past year, 36 patients have been treated thus far with 11 more scheduled. In the interest of good medical practice and evaluation of the efficacy and toxicities inherent with this program, a data base has been established to document outcomes. The RTOG scoring system for prostate brachytherapy will be used for the purpose of tracking bowel and sexual function toxicity. The I-PSS (International Prostate Symptom Score) is completed by each patient baseline and with every subsequent visit.



This graph compares the results of certain dosimetric parameters, V100 and D90, for post-op implants done in Albany with the results obtained by the Seattle VA (Wallner) and the results of Butler. Both Wallner and Butler have published their results in the International Journal of Radiation Oncology, Biology, and Physics. V100 is the volume of the prostate receiving 100% of the prescribed dose. D90 is the dose that covers 90% of the prostate and it should be ≥ the prescribed dose, i.e., > 100 The implants done at Stratton compare favorably with those done at other institutions.

Brachytherapy outcomes will be discussed in the Cancer Committee on a biannual basis.

The Radiation Oncology department is a teaching site for the Radiation Therapy Technology program based at Upstate Medical Center in Syracuse NY. Students rotate through the department and have experiences in radiation therapy treatment and planning, dosimetry and nursing. The department is also a teaching site for dental and pharmacy residents as well as students of nursing, dietary and rehabilitation medicine.

The highest levels of quality care are assured via a detailed CQI process. A non-treating physician reviews all new patient's charts and treatment plans on a weekly basis in "chart rounds". This process assures appropriateness of plans and often initiates discussions that are pertinent to specific patients and disease sites. All other charts are checked weekly for completeness.

The multi-disciplinary CQI team meets on a monthly basis and reports on the monitors that are specific to their section. Medical CQI focuses on issues related to unexpected deaths, reasons for delays in treatments and unexpected outcomes. The patient's treatment plan is reviewed for instance, in the event of a potentially dangerous RT related incident. CQI in Nursing focuses on RT side effects, weight loss in head and neck patients and implementation of Advanced Directives as well as monitoring of consult notes for content that is felt to be pertinent. This information includes such items as complete AJCC TNM staging including group staging, documentation of an exact plan of care and inclusion of Karnofsky performance status and pain scale. Currently, there is 99% compliance with our goal for education/completion of Advance Directives for all Radiation Oncology patients. This achievement is the result of the dedicated work of our Oncology social worker, Ed Cunniff's commitment to achieving the highest level of comprehensive cancer care for all of our veteran patients. The RT consult notes are also 100% compliant with complete staging, up significantly from the previous year of 82%. There is a 98% follow up rate and a very high level of patient satisfaction achieved at 98%.

A cancer committee goal that the department is actively involved with is the timeliness of treatment of head and neck patients. For the sake of coordination, an e-mail group was developed that includes all of the clinicians involved in the patient's care. Once a new malignancy is identified, an e-mail is sent to the group in order to coordinate the services of Radiation and Medical Oncology, Dental, Nutrition and Speech/Swallowing therapy. This system has worked well to not only coordinate but to communicate among the services during treatment of the patient.

Simulations (treatment planning) for all definitive cases are accomplished in conjunction with a diagnostic/planning CT scan. This 3-D planning not only offers the most current information in relation to the patient's tumor, but also allows for precise field configuration that minimizes RT effects on normal structures while optimizing the radiation effect on the tumor. 3-D planning continues to be our standard operating procedure for definitive treatment. Our computerized planning equipment was upgraded in July 2003 to the most state of the art equipment available. The new system with its' faster calculation engine enables modification of plans and rapid calculations of display of isodoses. This in turn minimizes the physician's time in the task of treatment planning and expedites the initiation of therapy for our cancer patient population.

In addition to the simulator machine, the department has 2 linear accelerators for treatment. Both are Varian machines. One is a Clinac 6 and the other is a Clinac 2100. The Clinac 2100 is the dual energy (photons and electron capability) machine that is adapted for the use as the linac based Stereotactic Radiosurgery. Cancer Program Director submitted Capital asset proposal for procurement of a new linear accelerator and record and verify system for FY' 06.

There are 2 registered nurses that work full time in the Radiation Oncology department. They share the workload for the treatment patients and perform case management for each radiation patient. They are each responsible for the coordination of care of their patients including travel, housing, management of RT side effects and coordination of support services. Both of the nurses are members of the advanced illness care team and follow patients in this regard as well. The patients are offered housing for treatment at either the Fisher House or the Hoptel Unit. Other support services that are coordinated through the RT department include nutrition, speech and swallowing therapy, pain management, physical therapy, social work service, Advanced Illness Care Coordinator (AICC) and home care services including Hospice. The nurses also coordinate the follow up of the patients and communicate the plan with the referring service. They work closely with referring hospitals in the coordination of patient treatment and transfer of information.

The clinical staff is active on the Tumor Board, the Comprehensive Cancer Committee, the 9B multidisciplinary care plan team and the Brachytherapy Planning Committee. Radiation Oncology Nursing is well represented in the community as Faculty for the North Eastern NY Oncology Consortium. This consortium was designed to elevate and standardize oncology nursing education in our region. Our Radiation Oncology nurse serves as faculty and active member of this consortium.

The Oncology Consortium member is an oncology certified nurse (OCN) and our Cancer Program Director is AOCN (Advanced Oncology Certified Nurse).

RADIOLOGY

1. Angiography - our Philips Intergris Angio Suite provides our hospital with many diverse options in imaging. We continue to see an increase in various line placement studies and other challenging interventional procedures. Our highly skilled technologists add high image quality and technical expertise. We are also asked to provide imaging assistance with Pain Management cases as well as Gastrointestinal and Pulmonary cases. The number of cases performed continues to increase as we continue to provide high quality patient care and imaging for the more demanding and interesting cases we do everyday!

2. MRI - our Philips Intera 1.5 Tesla MRI Suite is an exciting success. There is a dramatic increase in the quality of our studies due to the increased field strength of this magnet as well as our Medrad Spectias MR injecter. Patients are quite pleased with the decreased scan times and new bright pleasant environment in the scanning room. The addition of the audio sound system has been the biggest hit! It provides a choice of listening music while drowning out the noise of the machine while it is scanning. We look forward to continuing to provide high quality exams at a faster pace as we continue to increase our capabilities.

3. The purchase of a high performance tube has helped numbers continue to increase in the CAT scan section of the Radiology Department. Improved quality and faster scan times are an immediate result of the installation of this tube. We continue to work closely with the Radiation Therapy and Oncology Departments to provide vital studies in the detection and treatment of cancer. There are minimal waiting periods for scheduled studies and acute patients remain a priority. Our experienced staff continues to shine in everyone eyes!

4. Vista Imaging is up and running within the hospital. The hospital staff is adjusting to looking at images on the Vista Imaging monitors instead of films. Cat Scan and MRI studies can be viewed immediately following their completion. In addition, Computed Radiography (CR) and Digital Radiography (DR)have recently been installed. This acquisition begins the process of a film-less Radiographic environment.

Our radiologists can view CAT scan and MRI call cases from home and provide emergent readings.

5. Mammography – These accomplishments and a review can be located under Women's Health.

6. Ultrasound - There has been a recent equipment upgrade for our Acuson Sequoia machine. This upgrade has improved the image quality of the studies.

7. Nuclear Medicine - We recently ordered a Dual Head Phillips gamma camera. This will greatly enhance sensitivity in screening cancer patients for metastases and monitoring their response to treatment. It will also decrease the amount of time and subsequently, patient discomfort, in these procedures. In addition, we have improved access of thyroid cancer patients to treatments and monitoring.

SURGICAL REPORT

The roles of surgical oncology are crucial in the comprehensive care of cancer patients. Among various treatment modalities, surgery is essential in providing potential cures of cancer. Surgeons play a central figure in the prevention, early detection, diagnosis, staging and management of almost all non-hematologic malignancies. A veteran coming to the Stratton VA Medical Center has a full complement of surgical expertise available.

The Department of Surgery at the Stratton VA Medical Center strives to ensure a comprehensive approach to the management of the surgical oncology patients. The team consists of surgeons from various specialties, such as general, thoracic, urological, ear-nose-throat and neuro surgeries. Since the Stratton VA Medical Center is a teaching facility, surgical residents and medical students are assigned to the VAMC. They are given opportunities to provide care for our veterans. In addition, there is access to University consultants of all specialties

From July 1, 2004 through June 30, 2005, the number of selected diagnostic procedures and number of patients diagnosed to have malignancy are listed in Table 1.

NUMBER OF DIAGNOSTIC PROCEDURES AND DIAGNOSED MALIGNANCIES
IN SELECTED SPECIALTY

THORACIC SURGERY	Bronchoscopy	39
	Thoracoscopy	5
	Resection of lung	21
	Cancer of lung & bronchus	36
GENERAL SURGERY	Colectomy	34
	Cancer of colon	21
	Cancer of rectum	10
UROLOGY	Cystoscopy	621
	Bladder cancer	66
	Biopsy of prostate	83
	Prostate cancer	48
	Kidney cancer	10
OTOLARYNGOLOGY	Operative laryngoscopy	40
	Biopsy of head neck lesions	21
	Esophagus endoscopy	24
	Cancer of nose	27

TABLE 1

The thoracic surgeons performed 39 bronchoscopies, 5 thoracoscopies, and 21 lung resections. There were 36 cancers of lung or bronchus diagnosed. General surgeons performed 34 colectomies for malignancy as well as benign lesions. There were 21 colon and 10 rectal cancers. The Urology Section performed 621 diagnostic cystoscopies as well as 83 trans-rectal ultrasound-guided prostate biopsies. ENT section performed 40 operative laryngoscopies, 21 biopsies of head and neck lesions. These procedures may include initial detection or provide follow-up surveillance for the possible recurrence of cancer disease.

All surgical specialties participate actively in weekly Tumor Board/Cancer Conferences as well as several other multi-service meetings where management of patients is discussed in a comprehensive manner. Surgery is well represented and remains a standing member and this past year provided Chairman of our Comprehensive Cancer Committee.

LARYNGEAL CANCER

Sixty-three analytic cases were captured during the review period. Figure 1 depicts the yearly caseload accruals. There has been a slight decrease in the number of patients with Laryngeal Cancer.

YEARLY CASELOAD ACCRUALS
2000 – 2004 LARYNX CANCER
(N-63)

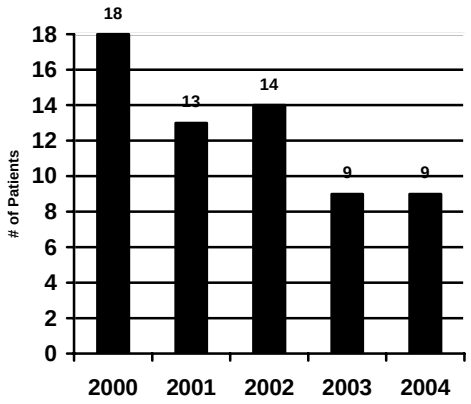


FIGURE 1

AGE AT DIAGNOSIS
2000 – 2004 LARYNX CANCER
(N=63)

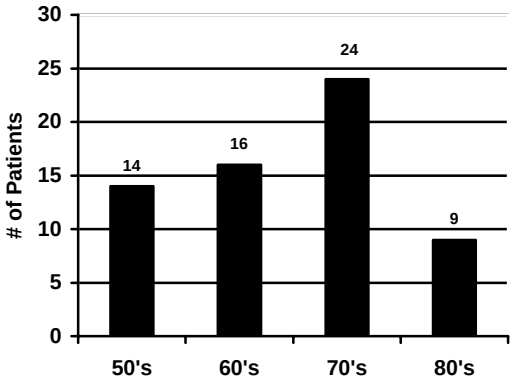


FIGURE 2

Figure 2 depicts the age at diagnosis for this group of patients. The vast majority of the patients are in their 70's. Statistics are as follows: 70's-38%, 60s-25%, 50's-22% 80's -15%.

The SEER stage at diagnosis is shown in Figure 3. 45% have localized disease, 11% have insitu, 6% have distant disease, and 38% have regional disease.

SEER STAGE DISTRIBUTION
2000 – 2004 LARYNGEAL CANCER
(N-63)

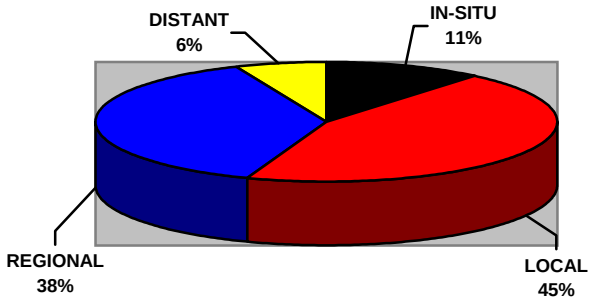


FIGURE 3

When compared to the data of the 1998 – 1993 review period, there has been an increase in the percentage of patients with in situ disease indicating probably more awareness for symptoms of laryngeal cancer and earlier diagnosis.

The AJCC Stage at diagnosis for the larynx is shown in Table I. 9.5% are Stage 0, 20.6% Stage I, 15.9% Stage II, 22.2% Stage III 30.1 Stage IV. Compared to the previous review period there has been an increase in (Stage 0) indicating earlier detection there has also been a slight increase of stage III patients and a slight decrease of Stage IV patients. The sample size is too small to make definitive conclusions.

TABLE I

AJCC STAGE DISTRIBUTION
2000 - 2004 LARYNGEAL CANCER
(N=63)

STAGE	#	%
0	6	9.5
I	13	20.6
II	10	15.9
III	14	22.2
IV	19	30.1
UNK	1	1.6

The larynx is subdivided into three sites: glottis or true vocal cord tumors, subglottic tumors, and supraglottic tumors. The larynx is a relatively small anatomic region. The sites are contiguous and there is often contiguous spread to the tumor from the site of origin to its contiguous site (glottic tumors can have a subglottic or supraglottic component or both, transglottic. Similar to the previous review, isolated subglottic tumors are rarely observed. Glottic tumors represent 58% and supraglottic tumors represent 35% of the total (Figure 4).

SUBSITE DISTRIBUTION
2000 - 2004 LARYNGEAL CANCER
(N-63)

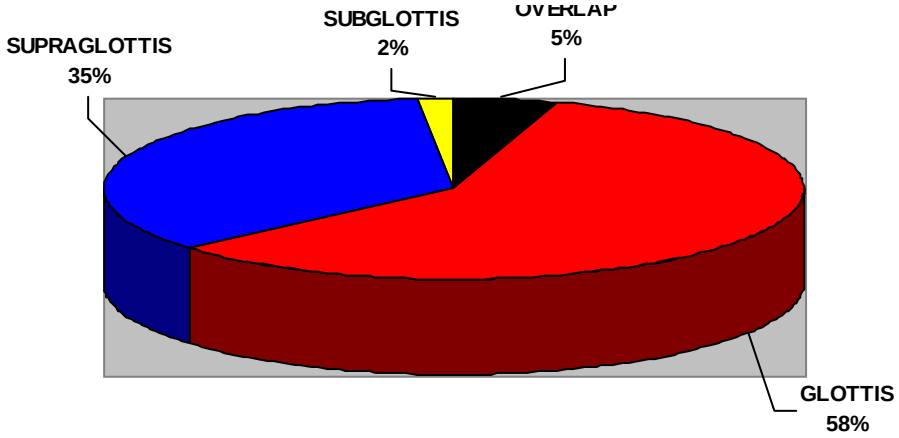


FIGURE 4

The initial treatment modalities are listed in Table II. Stage 0 is mainly treated via Laser excision except in 2 cases for recurrence or anatomical reasons- Stage I

and II were mainly treated with Radiation as to preserve the laryngeal function. Stage III and IV were mostly divided between Chemoradiotherapy as a combined modality with the purpose of organ preservation and surgery followed by adjuvant Radiation.

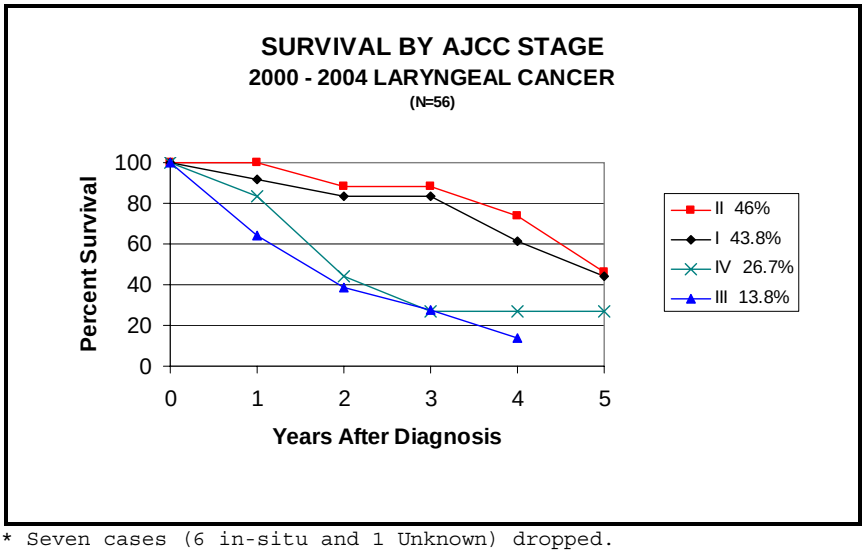
TABLE 2

INITIAL TREATMENT BY AJCC STAGE
2000 - 2004 LARYNGEAL CANCER
(N-63)

TREATMENT	0	I	II	III	IV	UNK	TOTAL
None	-	1	-	-	1	-	2 (3.2%)
Radiation Only	1	10	9	3	5	-	28 (44.4%)
Surgery Only	4	-	-	3	2	1	10 (15.9%)
Surg/Radiation	1	2	1	5	6	-	15 (23.8%)
Chemo/Radiation	-	-	-	2	5	-	7 (11.1%)
Surg/Radiation/Chemo	-	-	-	1	-	-	1 (1.6%)

When compared to the previous review period treatment modalities are essentially unchanged except for a slight increase in the frequency of use of combined modality treatment (concomitant Chemo – Radiotherapy for more advanced stages).

Survival by AJCC stage is shown in Figure 5. Overall survival for stage I and II at 5 years was between 44% and 46%. It was 13.8% for Stage III, and 26.7% at 5 years for Stage IV. When compared to the previous data there has been a decrease in survival for Stage III patients, but improved overall survival for Stage IV patients. However 27% of Stage I, II, and III patient's died of other causes and were free of laryngeal cancer at time of death. Therefore the disease specific survival compares favorably with the National averages. Overall survival for Stage I, II, and III is 35% at 5 years approximately. However the disease specific survival overall for Stage I, II, III at 5 years is 60%. This difference is probably due to an older population in recent review and their subsequent increase co- morbidities.



* Seven cases (6 in-situ and 1 Unknown) dropped.

FIGURE 5

The survival by type of treatment is illustrated in Figure 6. There is a lower overall survival of patient treated with Surgery, but this is mainly due to older population and the increase use of combined Chemo and Radiotherapy for organ

preservation. In fact, there is an increase of the overall survival when Chemo and Radiotherapy is used (28% in this review compared to 18% in the previous review.

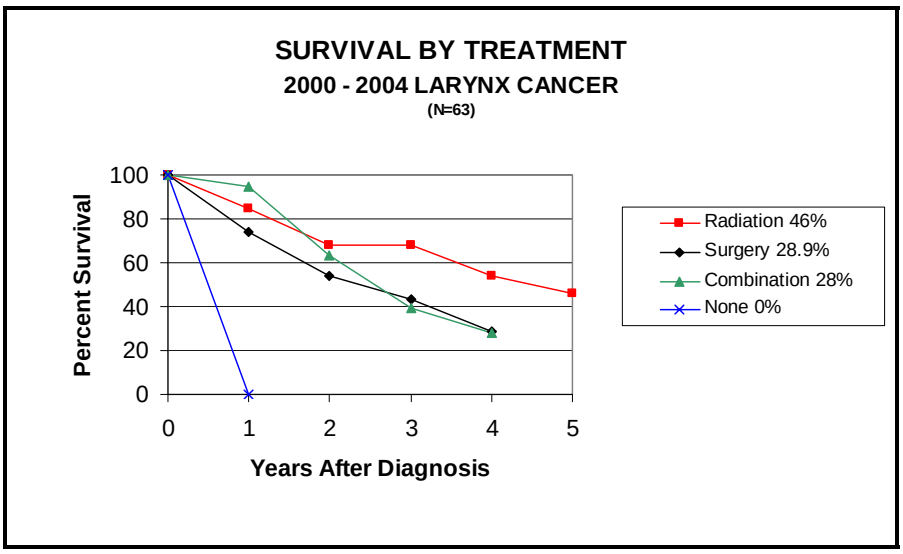


FIGURE 6

The overall 5 year survival, Figure 7 is approximately 30%; this is slightly lower than the previous overall survival. This might be the result of an older population with increased co-morbidities. However, as mentioned earlier the Laryngeal –specific survival compares favorably with National averages

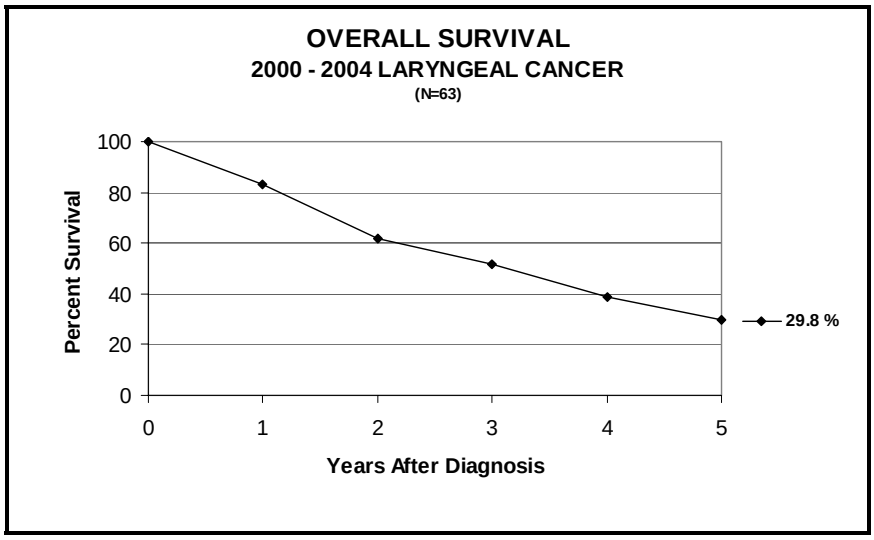


FIGURE 7

Conclusion: Our data doesn't reflect completely disease specific survival which measures survival based on death due to laryngeal cancer. The older and more ill the patient population studied, the more inaccurate the survival curve will be if not disease specific. So, for example, if a patient dies of heart disease before the end of the 5 year survival date, he will be counted as a death and thus will inaccurately lower the survival curve. To obtain true disease specific data from our patients would require IRB permission, contacting patient's families, doing a thorough chart review and a prospective study on these patients which is beyond the scope of the annual report.

CONTRIBUTORS

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